South Dakota Board of Nursing's HPAP — Health Professionals Assistance Program

Enrollment & Application Instructions

Thank you for your interest in enrolling and participating in HPAP.

Please complete and submit all required documents listed below to Midwest Health Management Services (MWHMS). Upon receipt of the *Initial Application* form, MWHMS will contact you to set-up an initial meeting within 10 business days. All forms must be received by MWHMS prior to the meeting.

Be advised:

- Upon submission of the application, you agree to complete the SDBON HPAP enrollment process.
- *Furnishing false information for enrollment or participation in HPAP may constitute cause for denial of admission or termination from HPAP and reporting to the board.*

Submit the following forms to MWHMS:

1. *Initial Application Form*. The information on the application helps MWHMS determine if you are eligible to enroll.
2. *Intake and History Form*. This information helps MWHMS determine if HPAP is indicated for you, if so, they will develop an individualized Participation Agreement for you.
3. *Authorization and Consent to Release Information Form*. This form allows HPAP staff to contact your healthcare providers, attorney, the Board of Nursing, and the Pharmacy Prescription Drug Monitoring Program.
4. *MWHMS Payment Agreement Form*. Please review and sign. Be advised, you are responsible for paying the costs of outside evaluations, treatment, toxicology, and support group attendance. MWHMS will take into consideration your financial resources and specific needs when making referral recommendations for evaluation, treatment, or continuing care.
5. *Unified Judicial Report.* Request a copy of your report from the Clerk of Courts at your local county courthouse. Submission of this report provides HPAP staff your legal history.

Submit required forms and documents to:

Midwest Health Management Services (MWHMS)
4109 S. Carnegie Cir
Sioux Falls, SD 57106

Enrollment Evaluation and Participation Agreement:

MWHMS staff will provide your completed forms and supporting documentation to the SDBON HPAP Evaluation Committee. Following review and approval by the committee to enroll you, the committee will provide recommendations for the development of your Participation Agreement (PA). All enrolled participants are required to have a signed PA on file with HPAP; you will be provided an opportunity to review and accept the PA. The PA may include recommendations for treatment, continued care, support group participation, toxicology, practice restrictions, worksite monitoring, filing of reports necessary to document compliance, and terms for successful completion of participation.

If you have questions, email: Midwest Health Management Services
https://www.mwhms.com/
We look forward to aiding you in this matter.

South Dakota Board of Nursing's H Health P Professionals A Assistance P Program

Application Fee: $200
Submit with application; cash or money order payable to MWHMS.

Initial Application Form

Name: Last_____ First_____ Middle:_____

Former Name(s) used:_____

Home Address: _____ City_____ State:_____ Zip:_____
Street/PO Box

Length of time at residence:_____

Telephone: Home_____ Cell_____ Other:_____

Email: _____

Date of Birth: _____ Social Security Number:_____

☐ Male ☐ Female ☐ Other

1. Provide your South Dakota nurse license number(s) and expiration date:
   - _____ Expiration date: _____
   - _____ Expiration date: _____
   - _____ Expiration date: _____

If you hold a SD nursing license, skip to question 4.

2. If you do not hold a SD nursing license, mark the South Dakota nursing license that you have applied for:

☐ LPN ☐ RN ☐ CNM ☐ CNP ☐ CRNA ☐ CNS

Or,

3. Mark the South Dakota approved PN or RN nursing program you are enrolled in:

Practical Nurse program:	☐ Lake Area Technical College	☐ Mitchell Technical College	☐ Presentation College	☐ Sinte Gleska University	☐ Sisseton Wahpeton College	☐ Southeast Technical College	☐ Western Dak. Technical College
Registered Nurse program:	☐ Augustana University	☐ Dakota Wesleyan University	☐ Lake Area Technical College	☐ Mitchell Technical College	☐ Mount Marty University	☐ Oglala Lakota College	☐ Presentation College
	☐ SD State University	☐ Southeast Technical College	☐ University of Sioux Falls	☐ University of SD	☐ Western Dak. Technical College		

4. Additional eligibility information:

a.	Do you have a history of disciplinary action against a license that may prohibit licensure in in South Dakota?	☐ Yes	☐ No
b.	Have you been mandated/board ordered to enroll in this program?	☐ Yes	☐ No
c.	Are you currently under investigation that may result in licensure discipline or a requirement to participate in this program?	☐ Yes	☐ No
d.	Have you had a history of nursing practice involving significant harm or death to a patient?	☐ Yes	☐ No
e.	Have you engaged in the diversion of drugs or substances for the purpose of sale or distribution to others?	☐ Yes	☐ No
f.	Have you fraudulently written a prescription?	☐ Yes	☐ No
g.	Have you been convicted of criminal behavior that includes crimes involving sexual misconduct, violence, or threatening behavior?	☐ Yes	☐ No
h.	Have you been terminated from this program or any similar program for noncompliance?	☐ Yes	☐ No
Provide an explanation for each YES response on a separate piece of paper, with a description of dates and circumstances; include ALL supporting applicable documentation.			
Pursuant to SDCL 36-2A-8, or rules promulgated under 36-2A-14, an applicant who answers yes may be denied enrollment; however, an applicant's situation will be reviewed, and enrollment may be allowed.			

Enrollment and Participation Records:
Be advised that in accordance with SDCL 36-2A, MWHMS will:

- Maintain the confidentiality of applicant or participant information and records.
- Only share application, enrollment, or participation records with the board under the following circumstances:
  - When an applicant is not compliant in the enrollment process;
  - When a participant fails to comply with program requirements; or
  - When a participant is Board Ordered/mandated to participate in HPAP.
- Only share a participant's records with other parties upon a participant's signed voluntary written release of the information.
- Exceptions to confidentiality include sharing a participant's information with medical providers in an emergency situation, with law enforcement upon imminent threats by a participant to harm themselves or others, or with state or local authorities for suspected child or elder abuse or neglect.

Informed Consent:
Be advised that upon signing this application, you, the undersigned, consent to MWHMS reporting your information to the board upon your failure to be eligible to participate in SDBON's HPAP, failure to cooperate with the admission process, failure to comply with HPAP terms of participation, signing of a board order mandating your participation in HPAP, or failure to pay costs or fees associated with participating in HPAP.

Attestation:
I, the undersigned, declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I am aware that should I furnish any false information, such an act may constitute cause for denial of admission or termination from HPAP and reporting to the board.

Applicant Signature **Date**

South Dakota Board of Nursing's HPAP — Health Professionals Assistance Program

Intake and History Form

Name: Last_____First_____Middle:_____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Describe the circumstances under which you were referred to HPAP, and who referred you:

_____

_____

List current stressors:

_____

_____

Family:

I am: ☐ Single ☐ Married ☐ Separated ☐ Divorced

List all members of your household and relationship to you: _____

_____

_____

Do you have children not living with you? If so, list their names, ages: _____

_____

_____

List how many times have you been married, and length of marriages? _____

_____

Does your significant other use drugs or alcohol? ☐ Yes ☐ No

If yes, what chemicals and explain further:_____

_____

_____

Have any of your children been diagnosed with a mental health or psychiatric illness? ☐ Yes ☐ No

If yes, please explain:_____

_____

_____

Mother's Alcohol/Drug Use: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Maternal family history of mental health or substance abuse issues/diagnosis: _____

_____

_____

Father's Alcohol/Drug Use: ☐ None ☐ Mild ☐ Moderate ☐ Severe
Paternal family history of mental health or substance abuse issues/diagnosis: _____

_____

_____

Are biological parents: ☐ Married ☐ Divorced ☐ Separated ☐ Never married
How long? _____

Have any brothers or sisters had alcohol/drug problems? ☐ Yes ☐ No
If yes, what chemicals and explain further: _____

_____

_____

Does your family know about your application to HPAP and why you are seeking application?
☐ Yes ☐ No ☐ N/A

Education, License, and Employment History:
List all post high school education and highest grade/degree: _____

_____

_____

List all professional licenses and license status: _____

_____

Current Employer: _____

How many hours per week do you work? _____

What is your present job title/department/responsibilities? _____

_____

Have you had problems at work? ☐ Yes ☐ No
If yes, mark applicable problems:

- Missing work? ☐ Yes ☐ No
- Late? ☐ Yes ☐ No
- Poor performance? ☐ Yes ☐ No
- Corrective Action? ☐ Yes ☐ No
- Is your position in jeopardy? ☐ Yes ☐ No

List the ways in which your present employment, or professional license has been affected by substance use, mental health, or behavioral issues (e.g. tardiness, absenteeism, accidents, poor performance, and conflict with co-workers, supervisors, or patients): _____

_____

_____

Who at work is aware of any concerns? _____

_____

Are these individuals supportive? ☐ Yes ☐ No

South Dakota Board of Nursing's HPAP (Health Professionals Assistance Program)

Employment and Military Service History:

Organization/Department:	Title:	Employment Dates/ Reason for Leaving:

Health History:

How would you describe your health? _____

_____

List all current physical health concerns, age of onset, and course of treatment: _____

_____

_____

Any serious injuries in your lifetime? ☐ Yes ☐ No
If yes, was this related to alcohol/drug use? ☐ Yes ☐ No
If yes, explain: _____

_____

Do you have recurring pain? ☐ Yes ☐ No
If yes, describe: _____

_____

When was the last time you saw a doctor? _____
List all physician/medical providers who are involved in managing your health: _____

_____

_____

List all prescribed medications, include dose and frequency of use: _____

_____

_____

List all regularly taken over the counter medications and supplements and reason for use:

_____

_____

Have physical symptoms led to missed time at work, required accommodations at work, or led to difficulties at work? ☐ Yes ☐ No
If yes, please describe: _____

_____

_____

If prescribed medication, have you used a higher dose or used more frequently than prescribed?
☐ Yes ☐ No
If yes, please describe: _____

_____

Have you received counseling or psychiatric care in the past? ☐ Yes ☐ No
If yes, did you require medical care? List below:

Date of Service:	Location:	Diagnosis/Reason for Service:	Leave for this illness or treatment?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Are you currently on or have you previously been prescribed medication to manage psychiatric symptoms? ☐ Yes ☐ No
If yes, list the medications, and when you started and discontinued these medications: _____

_____

_____

Did your prescriber recommend discontinuing these mediations? ☐ Yes ☐ No *or,*
Did you discontinue on your own? ☐ Yes ☐ No

Do you have a history of emotional trauma, or any form of abuse? ☐ Yes ☐ No
If yes, explain: _____

_____

_____

Has anyone told you, or do you believe you have difficulty managing feelings of anger? ☐ Yes ☐ No
If yes, describe:_____

_____

Have you destroyed property due to anger? ☐ Yes ☐ No
Have you hurt anyone due to anger? ☐ Yes ☐ No
If yes, describe: _____

_____

_____

Do you ever think of seriously hurting or killing someone? ☐ Yes ☐ No
If yes, explain: _____

_____

_____

What helps you in managing these feelings? _____

_____

_____

Are you currently experiencing feeling of hopelessness? ☐ Yes ☐ No
Have you ever had thoughts of suicide? ☐ Yes ☐ No

What helps you in managing these feelings? _____

_____

Are you thinking of suicide now? ☐ Yes ☐ No
Have you attempted to end your life? ☐ Yes ☐ No
If yes, please discuss nature and circumstances of attempt(s) and date(s): _____

_____

_____

If "yes" was alcohol or drug use involved:
Before? ☐ Yes ☐ No During: ☐ Yes ☐ No After: ☐ Yes ☐ No

Have emotional or psychiatric symptoms led to missed time at work, required accommodations at work, or led to difficulties at work? ☐ Yes ☐ No
If yes, describe:_____

_____

Have you felt that you use too much alcohol or other drugs? ☐ Yes ☐ No
Have you tried to cut down or quit using alcohol or other drugs? ☐ Yes ☐ No
Have you had health problems related to alcohol or other drugs? ☐ Yes ☐ No
Have you been injured after using alcohol or other drugs? ☐ Yes ☐ No
Has your use of alcohol/other drugs caused problems between you and family/friends? ☐ Yes ☐ No
Has your use of alcohol or other drugs contributed to missed school or work or school? ☐ Yes ☐ No
Has your use of alcohol/drugs affected your performance at work or school? ☐ Yes ☐ No
Have you lost your temper, gotten into arguments, or fights while using alcohol/drugs? ☐ Yes ☐ No

Are you finding you are using more alcohol/drugs in greater amounts or increased frequency to get the effect you want? ☐ Yes ☐ No

Amount spent per ☐ week ☐ month on alcohol? $_____
Amount spent per ☐ week ☐ month on drugs? $_____

Do you spend a lot of time thinking about or trying to get alcohol or other drugs? ☐ Yes ☐ No

When using alcohol or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? ☐ Yes ☐ No

Do you feel bad or guilty about you use of alcohol or other drugs? ☐ Yes ☐ No

Mark if you have:

☐ Had blackouts, memory loss, or trouble remembering what you did or said
☐ Felt sick, shaky, or depressed when you stopped use
☐ Injured your head after using alcohol or drugs
☐ Had convulsions, delirium tremens
☐ Had hepatitis or other liver problems
☐ Been injured after using alcohol or drugs
☐ Used needles/IV/IM drug use

Have you sought help because of your drinking or drug use? (i.e. Alcoholics Anonymous, Narcotics Anonymous, church, counselors, or a treatment program) ☐ Yes ☐ No

Please list all alcohol or drug treatment services (inpatient, outpatient, individual):

Date of Service:	Location:	Reason for Service:	Required Time Off or Medical Leave for this illness or tx?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Legal History:

List all prior arrests and legal charges (DUI's included) with the most recent first:

Date:	Charge:	Outcome:	Mark if Drug or Alcohol related:
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Current involvement with the legal system:

List pending court dates: _____

Probation Officer's Name: _____

Parole Officer's Name: _____

Attorney's Name: _____

Driver's License Suspended: ☐ Yes ☐ No
Awaiting Trial: ☐ Yes ☐ No
Awaiting Sentence: ☐ Yes ☐ No
Other: _____

_____

If you have had alcohol related arrests, please answer the following:
Why did the police stop you or arrest you? _____

_____

What was your BAC at the time of your arrest? _____

If applicable, how much alcohol would you estimate you had to drink the arrest? _____

_____

How many times or how often have you driven intoxicated in your lifetime, with no arrest? _____

_____

Social Summary:

With whom do you spend most of your free time? _____

_____

Would you have support to participate in mental health or substance use treatment, and/or abstaining from alcohol/drug use? ☐ Yes ☐ No

Do you have any problems paying bills or handling money? ☐ Yes ☐ No

What are your recreational interests, how do you spend your free time? _____

_____

_____

Spirituality:

Religious preference: _____

Do you consider yourself a spiritual person? ☐ Yes ☐ No

Do you have a belief in a higher power? ☐ Yes ☐ No

Please describe your strengths: _____

_____

Tell us about a period of success you had in your life: _____

_____

_____

What strengths contributed to that success? _____

_____

South Dakota Board of Nursing's HPAP — Health Professionals Assistance Program

Rate on a scale of 0-5, with 0 meaning it is not a difficult area in your life presently, up to 5 meaning it is a major concern in your life now.

Mark your rating to the following:	0 (not difficult)	1	2	3	4	5 (major concern)
I approach new situations with enthusiasm						
I am achieving goals I have set						
I can express my feelings appropriately						
I ask for support when I need it						
I recognize when I am stressed						
I act defensively to constructive criticism						
I become easily frustrated						
I hold on to anger/resentments						
I react with aggressive or violent behavior						
I need education about substance use						
I have low level of motivation for sobriety						
I struggle with cravings						
I experience relapse/unable to stay sober						
I am unable to control substance use						
I actively maintain contact with others						
I am distrustful of others						
I have supportive friends/relationships						
I am lonely/isolated/withdrawn						
I am shy/afraid to talk to others						
I tend to blame others for my problems						
I prioritize self-care						
I eat a well-balanced diet						
I take time out for myself when needed						
I keep myself physically fit						
I know my strengths and weaknesses						
I experience frequent feelings of remorse						
I experience frequent feelings of shame						
I experience feelings of low self-worth						
I am experiencing depression/despair						
I have financial/budgeting concerns						
I have feelings of anxiety/stress/can't relax						
I know how to relax under pressure						
I have a positive view of my future						
I have hobbies/ activities outside of work						
I feel valued in my vocational/career						
I organize my time and prioritize tasks						
I have medical/physical concerns						

Attestation:
I, the undersigned, declare and affirm under the penalties of perjury that this Intake and History Form has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I am aware that should I furnish any false information, such an act may constitute cause for denial of admission or termination from HPAP and reporting to the board.

Applicant Signature _____ Date _____

South Dakota Board of Nursing's HPAP Health Professionals Assistance Program

Authorization and Consent to Release Information Form

I, _____, _____
Name *DOB*

authorize Midwest Health Management Services, and/or the South Dakota Board of Nursing's Health Professionals Assistance Program (HPAP), to disclose and communicate per mutual unrestricted release of information to the individuals/entities listed below and authorize these individuals/entities to release any requested information to MWHMS/HPAP. I release from any and all liability and agree not to take legal action against MWHMS/HPAP, or any authorized representative of MWHMS/HPAP, for any matter arising out of the release of information by MWHMS/HPAP to agreed upon parties.

Name:	Phone Number:	Address:

- Complete Treatment Needs Assessment/Evaluation Findings (mental health or SUD)
- Discharge Summary (mental health or SUD)
- Continued Care Recommendations (mental health or SUD)
- Counseling/Psychiatric/Psychological Records (mental health or SUD)
- Participation Agreement
- Urine Drug Screen/Toxicology Reports/Soberlink/Affinity eHealth/Affinity Empowering/Recovery Trek
- Worksite monitoring
- Medical records/lab results
- Legal Records
- SD PDMP (South Dakota Prescription Drug Monitoring Program/Profile)

I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

Duration of involvement

_____
Date/Event/Condition

_____ _____
Participant Signature *Date*

_____ _____
MWHMS Staff Signature *Date*

This information has been disclosed to you from records protected by Federal confidentiality rules, 42 CFR part 2, and HIPAA. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2, and HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

South Dakota Board of Nursing's HPAP — Health Professionals Assistance Program

SD BON HPAP Payment Agreement Form

Initial each item:	**I understand and accept the following payment conditions for enrollment as a participant in the SDBON's HPAP. The SD Board of Nursing determines payment and funding responsibilities annually.**
	I agree to submit a fee of $200 with the *Initial Application* (Form 1). Payment must be cash, check, or a money order payable to MWHMS.
	I understand the expense to participate in HPAP is $3,000 per year.
	I understand that if I am a participant with an active SD nursing license, my cost to participate is shared with the Board of Nursing. I will be responsible to pay $312.50 per quarter. I will submit payments no later than January 7th, April 7th, July 7th, and Oct 7th. Payments may be cash, check, or a money order payable to MWHMS. Credit card payments will be expected but due to additional fees required for use will have a $10 added fee.
	I understand that if I am a participant who does not hold an active SD nursing license, I am responsible to pay $750 per quarter. Payment will be due by January 7th, April 7th, July 7th, Oct 7th. Payments must be cash, check, or a money order payable to MWHMS.
	I understand that if I am delinquent in payments, payments will be subject to a 10% service fee if payment is not received by the 7th.
	I understand non-sufficient fund or returned checks will result in an additional $50 service fee.
	I understand that all fees are non-refundable.
	I understand that failure to meet my financial responsibility may result in termination from HPAP and reporting to the board.

_____ _____

Participant Signature Accepting Terms of Financial Responsibility *Date*

Updated 6/1/2022